TEENAGERS AND SEX

Do parents have a right to know?

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By Phil Gleeson

Recent research indicates that between 20% and 30% of teenagers are sexually active by the age of 16, and that adolescents consider medical professionals to be an important source of information about sexuality and contraception.[1]

Earlier this year, a contentious Bill came before the Commonwealth Parliament that raised the issue as to whether the Therapeutic Goods Administration or the Minister for Health should have the last word on making the so-called 'abortion pill' (RU486) available to Australian women.[2] It was unfortunate – but not unexpected – that the debate spilled over into the morality of pregnancy termination itself (a medical procedure already widely available). Minister Abbott weighed into the debate by suggesting that pre-termination counselling should by law include messages from pro-life organisations such as the Catholic Church.

In an odd coincidence, while this debate raged in Australia, the UK High Court was being asked to consider how doctors should advise and treat young people who seek advice and treatment on sexual matters, including abortions, and whether a young person's right to confidentiality and privacy should be limited.

In *Axon, R (on the application of) v Secretary of State for Health & Anor*,[3] Sue Axon sought a declaration in the High Court of England and Wales that in certain very particular circumstances doctors should not be obliged to keep confidential their patients' information. In fact, Ms Axon argued, doctors in such circumstances ought to be under a duty to disclose confidential information to third parties. The particular circumstances Ms Axon had in mind were when either of her youngest daughters[4] found themselves seeking medical advice regarding matters of their sexual health, including contraception and abortion. Ms Axon wanted UK law to recognise that doctors should consult

parents where a person under the age of 16 was seeking advice on such matters. In light of Minister Abbott's pronouncements, it is not difficult to imagine conservative members of our own Commonwealth legislature taking a similar view.

In her application, Ms Axon relied on the well-known majority judgment of the House of Lords in *Gillick v West Norfolk and Wisbech Health Authority*[5] (*Gillick*), and Article 8(1) of the European Convention on Human Rights (ECHR).

BACKGROUND

Statutory presumption of capacity

In the UK, the *Family Law Reform Act* 1969 provides that any person over the age of 16 is presumed to have the same capacity as an adult to consent to surgical or medical treatment.[6]

Historically, it had been assumed that the provisions of the UK *Family Law Reform Act* were intended to be without prejudice to the position at common law – that is, if a child under the age of 16 nonetheless had the capacity to consent, then the introduction of the Act did not change that. This interpretation was challenged in *Gillick*, where the claimant argued that a parental right to consent was preserved and no child under the age of 16 could consent where surgical or medical treatment is proposed.

Gillick's case

The majority in *Gillick* recognised that competent minors had the right to consent to medical treatment. The Appellate Committee majority held that a doctor could give medical advice and treatment (that is, prescribe the oral contraceptive pill) to a girl under the age of 16 if she had sufficient maturity and intelligence to understand the nature and implications of the proposed treatment and *provided that certain conditions were satisfied*.

Lord Fraser made the following remarks in a speech, with which Lord Scarman and Lord Bridge expressly agreed:

> 'The only practicable course is to entrust the doctor with a discretion to act in accordance with his view of what is best in the interests of the girl who is his patient. He should, of course, always seek to persuade her to tell her parents that she is seeking contraceptive advice, and the nature of the advice that she receives. At least he should seek to persuade her to agree to the doctor's informing the parents. But there may well be cases, and I think there will be some cases, where the girl refuses either to tell her parents herself or to permit the doctor to do so and in such cases, the doctor will, in my opinion, be justified in proceeding without the parent's consent or even knowledge provided he is satisfied on the following matters (1) that the girl (although under the age of 16 years of age) will understand his advice; (2) that he cannot persuade her to inform her parents or allow him to inform the parents that she is seeking contraceptive advice; (3) that she is very likely to begin or to continue having sexual intercourse with or without contraceptive treatment; (4) that unless she receives contraceptive advice or treatment her physical or mental health or both are likely to suffer; (5) that her best interests require him to give her contraceptive advice, treatment or both without the parental consent.'[7]

The 2004 guidance

In 2004, the UK Department of Health published a document entitled *Best Practice Guidance for Doctors and other Health Professionals on the Provision of Advice and Treatment to Young People under 16 on Contraception, Sexual and Reproductive Health* ('the 2004 Guidance'), which deals with the 'duty of care' owed by doctors and health professionals. It states that:

> 'Doctors and other heath professionals … have a duty of care, regardless of patient age.
>
> A doctor or health professional is able to provide contraception, sexual and reproductive health advice and treatment, without parental knowledge or consent, to a young person aged under 16, provided that:
>
> She/he understands the advice provided and its implications.
>
> Her/his physical or mental health would otherwise be likely to suffer and so provision of advice or treatment is in their best interest.
>
> However, even if a decision is taken not to provide treatment, the duty of confidentiality applies, unless there are exceptional circumstances as referred to above.[8]

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The personal beliefs of a practitioner should not prejudice the care offered to a young person. Any health professional who is not prepared to offer a confidential contraceptive service to young people must make alternative arrangements for them to be seen, as a matter of urgency, by another professional. These arrangements should be prominently advertised.'

The practice to be adopted by medical professionals is explained in the 2004 Guidance under the heading 'Good Practice in Providing Contraception and Sexual Health to Young People under 16', as follows:

'It is considered good practice for doctors and other health professionals to consider the following issues when providing advice or treatment to young people under 16 on contraception, sexual and reproductive health.

If a request for contraception is made, doctors and other health professionals should establish rapport and give a young person support and time to make an informed choice by discussing:

- The emotional and physical implications of sexual activity, including the risks of pregnancy and sexually transmitted infections.
- Whether the relationship is mutually agreed and whether there may be coercion or abuse.
- The benefits of informing their GP and the case for discussion with a parent or carer. Any refusal should be respected. In the case of abortion, where the young woman is competent to consent but cannot be persuaded to involve a parent, every effort should be made to help them find another adult to provide support, for example another family member or specialist youth worker.
- Any additional counselling or support needs.

Additionally, it is considered good practice for doctors and other health professionals to follow criteria outlined by Lord Fraser in 1985, in the House of Lord's ruling in the case of *Victoria Gillick v West Norfolk and Wisbech Health Authority and Department of Health and Social Security.* These are commonly known as the "Fraser Guidelines":

- the young person understands the health professional's advice;
- the health professional cannot persuade the young person to inform his or her parents or allow the doctor to inform the parents that he or she is seeking contraceptive advice;
- the young person is very likely to begin or continue having intercourse with or without contraceptive treatment;
- unless he or she receives contraceptive advice or treatment, the young person's physical or mental health are both likely to suffer;
- the young person's best interests require the health professional to give contraceptive advice, treatment or both without parental consent.'

The court in *Axon* was asked, in effect, to consider whether the 'Fraser Guidelines' in the 2004 Guidance (attempts to paraphrase Lord Fraser's guidelines, quoted above) summarised the law properly and accurately.

THE UK HIGH COURT PROCEEDINGS

The judgment describes how, 20 years ago, Ms Axon herself had undergone an abortion, which she continued to regret. Her commencement of these proceedings springs from, in part, her hope that neither of her daughters would have to face the experience of an abortion without the assistance and guidance of their mother. She also felt that the 2004 Guidance undermined her role as a parent.[9]

Ms Axon sought declarations reframing the doctor's duty to include *a duty to inform parents* and making the 2004 Guidance unlawful. The Secretary of State for Health is the authority responsible for publishing and distributing the document, and the Family Planning Association was granted leave to intervene on the basis of its status as the UK's leading sexual health charity, working to improve sexual health reproductive rights for everyone in the UK.

THE APPLICANT'S CASE

Counsel for both the applicant and the defendant relied upon the House of Lords decision in *Gillick*. Neither side sought to argue that *Gillick* was wrongly decided. 'The case for Ms Axon was therefore one of emphasis. In other words, does a 'mature' minor gain all the benefits of a doctor:patient relationship, or just some? Should the triangular relationship of doctor, child and child's parent be preserved?

Ms Axon sought the following relief:

'1. A declaration that the 2004 Guidance is unlawful in that it:

(1) misrepresents the decision of the House of Lords in Gillick whilst purporting to clarify it;

(2) makes doctors and other health professionals the sole arbiters of what is in the best interests of a child;

(3) makes informing parents the exception rather than the rule;

(4) excludes parents from important decision-making about the life and welfare of their child;

(5) fails in any event to discharge the state's positive obligation to give practical and effective protection to the claimant's rights under article 8(1).

2. A declaration that, other than in circumstances where disclosure would be likely to damage the child's physical or mental health –

(1) doctors and other health professionals have a duty to consult the parents of a young person under 16 before providing advice and/or treatment in respect of contraception, sexually transmitted infections or abortions;

(2) parents have a right to be informed about the proposed provision of advice and/or treatment in respect of contraception, sexually transmitted infections or abortions.'

Ms Axon's major submission as described by the UK High Court was that the duty owed by a medical professional to a young person should be defined in the following terms:

'The doctor is under no obligation to keep confidential advice and treatment which he proposes to provide in respect of contraception, sexually transmitted infections and abortion and must therefore not provide such advice

and treatment without the parents' knowledge unless to do so would or might prejudice the child's physical or mental health so that it is in the child's best interest not to do so. The claimant's primary case is that this represents the nature and scope of the doctor's duty of confidence in respect of all the above treatments. However, the claimant's alternative case is that, at the very least, this is his duty in respect of the provision of advice and treatment in respect of abortion.'[10]

In light of the way that the submissions had been framed, the UK High Court dealt with matters of sexual health in the general sense and then chose to deal with the issue of abortion separately.

THE FINDINGS OF THE UK HIGH COURT

Despite the applicant's efforts, the UK High Court found no assistance from overseas authorities that had dealt with similar issues such as access to abortion.[11]

The orders sought by Ms Axon were not granted for the following reasons:

1. The reframing of the duty as asked by Ms Axon would not be consistent with the decision of the Law Lords in *Gillick*. A close look at submissions from the applicant in *Gillick* revealed a similar argument for a positive duty to notify parents. So the High Court held that the existence of a duty to notify parents had in fact been implicitly rejected by the majority of the Appellate Committee in *Gillick*. Moreover, the reasoning of the Law Lords in *Gillick* was inconsistent with such a duty. This reasoning was that the parental right to determine whether a young person will have medical treatment terminates if and when the young person achieves a sufficient understanding and intelligence to understand fully what is proposed. It cannot therefore follow that a decision made by such a patient not to notify third parties did not mean that treatment could not be given. Lord Fraser, in particular, expressly anticipated circumstances where a doctor need not notify a young person's parents.
2. A positive duty on doctors to inform parents about medical treatment for young people would act as a disincentive for young patients to seek professional assistance and advice. Matters of sexual health, by definition, deserve the highest degree of confidentiality, regardless of age. And any reduction in the number of young people seeking advice on matters of sexual health would be contrary to public interest.
3. The rights and autonomy of children have become increasingly recognised. In its conclusions, the High Court makes reference to principles of family law,[12] the ECHR, and also the UN Convention on the Rights of the Child, describing a 'change in the landscape of family matters'.[13]

Largely for the reasons set out above, the UK High Court also found against the applicant's submissions that somehow abortion was medical treatment that ought to be distinguished from general matters of sexual health and contraception.

Without any great exposition of principle, the UK High Court also found, in a line-by-line analysis, that the 2004 Guidance was not unlawful or inconsistent with the 'Fraser Guidelines' deriving from *Gillick*.

Finally, it had also been argued that secrecy was destructive of family life and so Ms Axon relied further upon Article 8(1) of the ECHR, which reads:

'Everyone has the right to respect for his private and family life, his home and his correspondence.'

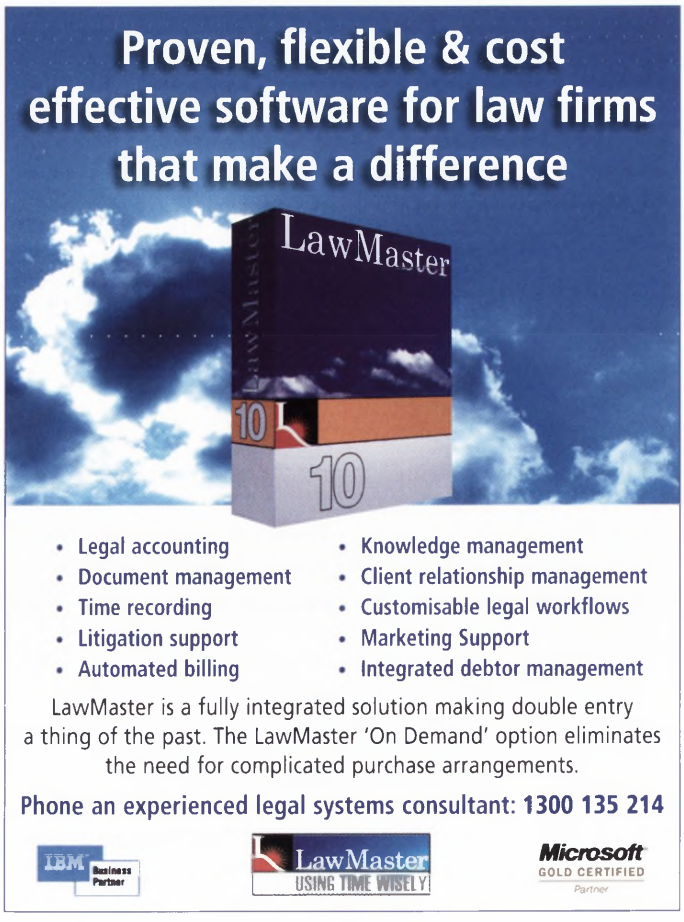
In the end, the High Court placed more weight on the significance of a patient's right to confidentiality and his or her parent's duty to act in their child's best interests than on parental rights of control over their children (which Ms Axzon argued was inferred from Article 8).

Will Australian courts be guided by *Gillick* and *Axon* and hold that competent minors have all the legal rights and responsibilities of a doctor:patient relationship, including the right to confidentiality and privacy?

AUSTRALIA

Consent to medical treatment

The right to self-determination is a fundamental principle that is part of the common law in many jurisdictions.[14] In Australia, the High Court has recognised the right of a patient to self-determination in *Secretary, Department of Health and Community Services v JWB & SMB*.[15] >>



Capacity to consent – minors

Problems arise, of course, in the case of a young person's capacity to consent or refuse medical treatment. Historically, Australian law recognised the basic principle that a child cannot consent to medical treatment. Consequently, a doctor must not treat a patient who is a minor without the consent of the child's parent. A minor remains a 'child' at law for most purposes until the age of 18.[16] This position was subject to the usual exceptions, such as emergency and statutory or judicial authority where a parent's consent (or the withholding of consent) can be challenged.

In reality, most parents would appreciate that as children grow up they gradually acquire autonomy. This process ideally occurs under the guidance of an adult or adults with parental supervision over a child. Tension is bound to occur at points where a child is exercising autonomy in a manner potentially in conflict with a parent's wishes. The Australian High Court has accepted that parental control diminishes as a child matures and it has consequently recognised the concept of the 'mature' minor.

In Marion's case, a majority of the High Court endorsed the UK High Court's decision in *Gillick* and found, quoting from that decision, that a child is capable of giving consent to medical treatment when s/he 'achieves a sufficient understanding and intelligence to enable him or her to understand fully what is proposed'. The issue of whether the child's confidentiality is thereafter preserved in that relationship was not dealt with by the High Court, nor has it been dealt with by a superior or appellate court in Australia.

Rights to privacy

It is not difficult to foresee Australian courts similarly dismissing an applicant who called for a positive duty to notify or inform parents where a child is seeking medical advice and treatment of issues relating to sexual health. The reasons cited by the UK High Court are just as valid in this country.

Perhaps more persuasive is the fact that in December 2001, all Australians were given new privacy rights. The *Privacy Act* 1988 (Cth) was amended to incorporate ten National Privacy Principles. These principles set out the minimum standard that health service-providers must apply when they collect, use and disclose health information. While the *Privacy Act* does not set an age at which a child or young person can exercise their own privacy choices, it does place obligations on doctors in the context of a doctor:patient relationship. Therefore, once a doctor decides that a child has capacity for the purposes of consent, all rights must surely follow.

Reading the judgment of the UK High Court in *Axon* gives one a sense that great respect was afforded by the court to the applicant and her counsel in what is, understandably, a deeply sensitive issue. Nonetheless, the conclusions make sense in a modern common-law context, where jurisprudence has more recently been influenced not only by an increasing awareness of the rights of patients,[17] but also by a 'family law' presumption that a child's welfare is the paramount consideration when determining issues concerning the upbringing of a child. ■

Notes: **1** Bartholomew TP and Carvalho T, 'General practitioners' competence and confidentiality determinations with a minor who requests the oral contraceptive pill' (2005) 13 *Journal of Law and Medicine*, 191 at 193. **2** Therapeutic Goods Amendment (Repeal of Ministerial Responsibility for Approval of RU486) Bill 2005 [2006]. **3** [2006] EWHC 37, a decision of the England and Wales High Court (Administrative Court). The judgment is available at http://bailii.org/ew/cases/EWHC/Admin/2006/37.html. **4** Said to be aged 12 and 15 in 2004 at the commencement of the proceedings. **5** [1986] 1 AC 112. **6** Section 8(3) of the *Family Law Reform Act* 1969. In contrast, the statutory age of majority for the purpose of consent to medical treatment throughout Australia is 18 years except in NSW and South Australia where the age is 14 and 16 years respectively. See *Age of Majority Act* 1974 (ACT), s5; *Minors (Property and Contracts) Act* 1970 (NSW); *Age of Majority Act* 1974 (NT), s4; *Age of Majority Act* 1974 (Qld), s5; *Age of Majority (Reduction) Act* 1970 (Qld), s3; *Age of Majority Act* 1973 (Tas), s3; *Age of Majority Act* 1977 (Vic), s3; *Age of Majority Act 1972* (WA), s5. **7** *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] 1 AC 112 at page 174B-D. **8** The 2004 Guidance makes earlier reference to exceptional circumstances such as where there is risk to the health, safety or welfare of a young person which is so serious as to outweigh the ethical and legal obligation to keep medical information confidential. **9** [2006] EWHC 37 at paras 15 – 18. **10** [2006] EWHC 37 at para 27. **11** Most notably, the US Supreme Court decision of *Roe v Wade* and the manner in which state legislatures have dealt with that decision. **12** The UK High Court quotes s1 of the *Children Act* 1989, but the author contends that similar attitudes would prevail in Australia when one considers the shift in emphasis in our own *Family Law Act* 1975 from concepts of custody, guardianship and access to concepts of 'best interests of the child'. **13** [2006] EWHC 37 at para 80. The UN Charter was ratified by the UK in November 1998. Article 12 provides that: 'States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.' Article 16 states that: 'No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation'. Article 18 provides that: 'States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians, have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their concern.' **14** In *Cruzan v Director, Missouri Department of Health* (1990) 110 S.Ct 2841, the US Supreme Court stated that 'No right is held more sacred, or is more carefully guarded ... than the right of every individual to the possession and control of his own person, free from all restraint or interference of others, unless by clear and unquestionable authority of law.' The right not to consent to treatment as a part of the broader right to self-determination was described by Mr Justice Cardoza in *Schloendorf v Society of New York Hospital* (1914) 105 NE 92 at 93, in the following terms: 'Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.' The application of the principle is perhaps best illustrated in Anglo-Australian common law by the UK decision of *Re B* [2002] 2 All ER 449. In that case, a 43-year-old woman suffered from a neurological condition and was dependent on respiratory support. She had no prospect of recovery and had requested that the ventilator be turned off. She made an application to the UK High Court seeking a declaration as to her capacity, the legality of her treatment and nominal damages. The court granted declarations of competence and unlawfulness of past and continued ventilation and awarded nominal damages. The court observed that where capacity to consent to or refuse treatment *was not in issue*, the wishes of the patient had to be respected regardless of the outcome. Clinical views as to the patient's best interests were therefore irrelevant. **15** (1992) CLR 218 ('Marion's Case'). **16** See note 6 above. **17** See *Rogers v Whitaker* (1992) 175 CLR 479.

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